Result Type:	Consultation
Performed Date:	July 17, 2011 4:32 PM
Result Status:	Final
Result Title:	CONSULTATION
Performed By:	[redacted] on July 17, 2011 4:32 PM
Encounter Info:	UPMCSHY, Inpatient, 7/17/2011 - 8/18/2011

* Final Report *

CONSULTATION

UPMC PRESBYTERIAN SHADYSIDE
PITTSBURGH, PA

CONSULTATION

NAME: [redacted]
ACCT #: [redacted]
PATIENT LOC: [redacted] SHY
ADMITTED: 07/17/2011
DATE OF CONSULT: 07/17/2011
DICT: [redacted]
ATTEND: [redacted]
Infectious Disease Consultation

This is a 23-year-old white female, who had previously been healthy. Her symptoms go back to about 6:30 when she developed some headaches, diffuse body aches, and fevers. She was treated symptomatically by her family doctor. She then developed nausea, vomiting, and more fevers. She was subsequently admitted to [redacted] Hospital on July 11, 2011. She had an MRI there that was unremarkable. She had, except for a punctate focus of increased signal in the right anterior pons on diffusion-weighted images, meninges were reported to be normal. She had an LP done which had 246 white cells with no neutrophils or lymphocytes, a few monocytes, and 1 eosinophil. There is a question of some atypical cells there, but that has been reviewed and they have been thought not to be abnormal lymphocytes. She over the last couple of days has developed diplopia. She also seemed to be somewhat confused.

PMH: Negative

ALLERGIES: SHE IS ALLERGIC TO PENICILLIN.

SOCIAL HISTORY: She does have a smoking history. She drinks occasionally.

FAMILY HISTORY: Positive for coronary artery disease.

REVIEW OF SYSTEMS:
CONSTITUTIONAL: No prior history of fevers, night sweats, or weight loss.

HEENT: No history of headaches, dizziness, passing out, or seizures.

HEMATOLOGIC/LYMPHATIC: No history of lymphadenopathy. The remainder of 10 point review of systems was negative.

PHYSICAL EXAMINATION:
GENERAL: She is a well-developed female, not in acute distress.

VITAL SIGNS: She is afebrile. Pulse rate 108, respiratory rate 18, and blood pressure 130/80.

HEENT: Her sclerae are nonicteric. There are no conjunctival lesions. She is repeatedly blinking her eyes because of her diplopia.

NECK: Supple.

LUNGS: Clear.

CARDIAC: Regular rate and rhythm. No murmurs, rubs, or gallops are heard.

ABDOMEN: Soft with active bowel sounds. Nontender.

MUSCULOSKELETAL: No clubbing, cyanosis, warm joints, or joint effusions.

SKIN: Normal turgor. No subcutaneous nodules. No rashes.

ASSESSMENT: Evolving neurologic picture going well into its third week now, developing new focal neurologic symptoms. The cause of this is unclear. I doubt this is a standard meningitis given the progression and time course. Tuberculosis is certainly a possibility. Fungal meningitis would also be a possibility. Viral syndrome such as EBV and CMV need to be ruled out. I would certainly recommend ruling out the acute retroviral syndrome. She needs to have a PPD placed. I would get HIV by PCR from a serum and an RPR. I understand the Lyme titers were drawn at [redacted] If we cannot locate these, they should be repeated. There is also a dermoid cyst on the CT of the abdomen. The case was discussed with the team on 7 Main.

Thank you for the kind referral.

[redacted]

IIS Job # [redacted]
SHY # [redacted]
D: 07/17/2011 16:32
T: 07/17/2011 17:47

cc: [redacted]
Fax: [redacted]
Fax: [redacted]
Authenticated and Edited by [redacted] On 8/14/11 10:21:12 AM